15400 Grand River 2nd. Floor Detroit MI, 48227

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POP SOLUTIONS CHW COVER SHEET

☐ Mr. ☐ Ms. ☐ Youth ☐ Senior ☐ Veteran ☐ Returning Citizen

First Name: Last Name:

Address: City:

State: Zip Code:

Phone Number: Email Address:

Social Services Requested

☐ Food ☐ Medical Insurance ☐ Medical ☐ Mental Health ☐ Water ☐ Lights/Gas ☐ Housing Assistance ☐ Eviction

☐ Workforce Development / Education ☐ Work/Jobs

Other Notes:

Does the client have insurance?

☐ Yes ☐ No ☐ Not Sure

Insurance Information

Name of Primary Health Insurance Co: Group Name:

Insured's ID: Group #:

Insurance Co. Address Group Address:

City: City:

State: State:

Zip: Zip:

Insurance Co. Phone Number: Group Phone Number:

☐ All information is assumed to be true to the best knowledge of the Community Health Worker. The CHW has seen the participants Valid ID and Insurance Card that match the name and address as verification. Or if the participant does not have health insurance all legal and valid documents have been physically reviewed.

CHW Name or ID#:

POPS CHW PROGRESS NOTE:

Participant ID: _____

DATE:		**VISIT TYPE:** ☐ In-Person ☐ Phone
LOCATION:		
TIME START:		**VISIT TYPE:** ☐ Educational ☐ Instrumental
TIME END:		

SHORT-TERM GOAL CHECK-IN:

Short-term Goal #1: (describe goal set by client)

Short-term Goal Progress:	Description of progress w/ Short-Term Goal #1:
☐ Success ☐ Partial Success ☐ No Success ☐ Did not try	

Short-term action plan for future:

☐ Continue same plan	☐ New Plan:	☐ No Plan

Short-term Goal #2: (describe goal set by client)

Short-term Goal Progress:	Description of progress w/ Short-Term Goal #1:
☐ Success ☐ Partial Success ☐ No Success ☐ Did not try	

Short-term action plan for future:

☐ Continue same plan	☐ New Plan:	☐ No Plan

POPS CHW PROGRESS NOTE:

Participant ID: _____

LONG-TERM GOAL CHECK-IN:

Long-term Goal: (describe goal set by client)

Client was reminded about long-term goal and stated confidence in achieving goal as:

(no confidence at all) 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Completely Confident)

VISIT CONTENT DISCUSSED:

☐ N/A – Instrumental Visit	☐ HTN 101
☐ Nutrition	☐ HTN 201
☐ Physical Activity	☐ Asthma 101
☐ Stress Management & Family Support	☐ Asthma 201
☐ Smoking Cessation	☐ Diabetes 101
	☐ Diabetes Complications

REQUEST FOR REFERRALS / RESOURCES:

REQUEST:	INFO PROVIDED / TO BE PROVIDED:
1.	
2.	
3.	
4.	
5.	

POPS CHW PROGRESS NOTE:

Participant ID: _____

CHW DESCRIPTION / ASSESSMENT / PLAN

DESCRIPTION:
ASSESSMENT:
PLAN: